Feeling the Squeeze

New rules are restricting the inpatient rehab sector. Can your facility adapt?

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As anyone familiar with managing an inpatient rehabilitation facility (IRF) knows, the last several years have been a rocky road for this sector. Although the transition from a cost-based model to the prospective payment system in 2002 was a financial boost for the industry, federal changes have resulted in a bust for many providers.

Beginning in 2004, key changes that impacted IRF providers, both in freestanding hospitals and rehab units, have included adjustments to the 75-percent rule and a more restrictive definition of medical necessity.

For IRF operators, the 75-percent rule and medical necessity criteria are the "rules of the game." These requirements for participating in the inpatient rehab program have been in place since 1983 to control admissions to certified inpatient facilities. They can be difficult to administer and track, and are in a perpetual state of flux. Many inpatient facilities find the rules cost-restrictive, and some have even been forced to close their doors.

But if you understand the intent behind the criteria, and look for strategies to work within the guidelines, you can identify alternate admission sources and position your facility in today's rehab markets.

GETTING TO THIS POINT

The original rule required that 75 percent of IRF admissions fall into one of 10 specific diagnostic categories. With a few exceptions, such as burns and congenital deformities, these diagnoses were mostly orthopedic, neurologic and traumatic injuries.

Patients in other categories, such as cardiology or oncology, generally didn't fall into the 10 allowed categories, even though many of these patients had functional limitations that could benefit from IRF care.

In 2004, under pressure from the rehab industry, the Centers for Medicare and Medicaid Services (CMS) increased the allowable diagnosis list to 13, and gave providers a 4-year window to comply. Eventually, President Bush signed legislation in January 2008 that permanently changed the 75-percent threshold to 60 percent.

In addition, many IRFs are grappling with the cloudier issue of medical necessity—the CMS requirement that any service provided to a Medicare beneficiary is medically necessary for the patient's specific condition and plan of care.

For IRFs, medical necessity means that any patient admitted into the program requires the level of care provided in an acute care setting. Also, the patient should be able to tolerate an intensive rehab program. Medical necessity attempts to prevent patients who could receive care in a less expensive level, such as skilled care or home care, from being admitted to an IRF.

These two factors have hit the IRF industry hard. From 2004 to 2007, Medicare admissions decreased 26 percent and IRF admissions declined 19 percent.

And fewer patients mean lower revenues. From 2005 to 2007, the Medicare profit margin for IRF providers dropped from 13 percent to 2.7 percent. Because Medicare represents 65 percent to 70 percent of all IRF admissions

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nationally, inpatient providers are feeling the squeeze. Many providers have downsized their programs to adjust to reduced volumes. Some have even closed.

REVERSING THE TREND

The good news is that managers can identify untapped opportunities to reverse the trend of declining admissions. IRF operators must look beyond the large, profitable orthopedic patient populations that have dominated core service lines.

In 2004, orthopedic patients represented 43 percent of IRF admissions. Yet, these patients experience the shortest length of stay among the major diagnostic categories, and typically have low acuity levels, measured by length of stay and case mix indices.

By shifting the focus away from higher acuity, medically complex patients and toward lower acuity, rapid rehab programs, many IRF programs had to demonstrate medical necessity. While growing orthopedic admissions met discharge placement needs of acute care hospitals, and provided a healthy bottom line for IRFs, the CMS focus on medical necessity took the wind out of those sails.

In addition, while a large rehab need exists for higher acuity patient populations, many IRF providers created artificial barriers to these populations. This occurred because they interpreted the rules incorrectly or limited clinical resources couldn't handle medically complex cases, such as stroke patients.

In fact, our market analyses have identified many areas and health systems in which appropriate IRF patients are admitted to skilled nursing settings, because IRFs deem them "too sick" for admission. But many patients admitted to IRFs are medically stable and can be treated in a skilled care setting.

In many markets, this has created a role reversal of these two programs. However, because of increasing CMS scrutiny, this trend simply can't continue.

TODAY'S IRF PATIENT

Despite losing orthopedic admissions, you can tap new populations and admission sources. IRFs hadn't considered high acuity patients appropriate for admission before, therefore many of them transitioned to skilled or long-term care, or remained in the acute setting for an extended time.

Based on our assessment of multiple markets, the potential increase in admissions by targeting higher acuity patients can offset the decrease in volume driven by the changes in the 75-percent rule and the focus on medical necessity.

In one example, a 40-bed inpatient rehab provider in the Midwest was experiencing a decline in IRF admissions due to a downturn in its orthopedic-based population. When this organization evaluated the IRF needs of its referring hospitals, it identified potential opportunities for patient populations that it hadn't targeted, due to their medical complexities.

In 2005, the facility admitted 519 orthopedic patients at an average daily census (ADC) of 10.0, and 195 neurology patients at an ADC of 5.9. By altering its focus to non-orthopedic diagnoses, the facility-projected numbers for 2008 are 210 orthopedic patients at an ADC of 6.9, and 305 neurology patients at an ADC of 14.2.

With additional adjustments, total admissions from 2005 to 2008 are projected to drop from 995 to 750, while ADC is projected to rise

from 26.8 to 30.6. This type of analysis is possible by reviewing patient-level information for specific acute care referral sources. Most communities can support 12 to 14 IRF beds per a population of 100,000.

Older communities have an IRF bed need toward the higher end of this range, while younger communities fall on the lower end. (This range reflects the legislation holding the threshold at 60 percent.) If your IRF beds aren't being used at these levels, you may be missing out on significant opportunities.

PUTTING DUCKS IN A ROW

Realigning your inpatient admissions isn't as simple as informing referral sources that you're willing to take on new patient populations. Before taking advantage of this opportunity, take steps to ensure your program can meet the needs of these new—and possibly more complex—patient diagnoses. Develop the following areas.

- *Medical staff coverage.* Is your medical staff comfortable managing medically complex patients? Your program's reputation depends on the physician least likely to accept medically complex patients. It's wise to assess your program's physical medicine and rehab coverage, and your use of consulting physicians.
- *Clinical staff competencies.* Do your acute care referral sources trust the clinical capabilities of your IRF clinical staff? If IRF patients are transferred back to acute care for issues addressed by acute care nurses, your credibility as an IRF can suffer.

Also, can the therapy staff develop care plans for medically complex patients that may require shorter and more frequent therapy sessions?

- *Admission criteria.* Most IRFs we've interviewed say they use admission criteria consistent with CMS conditions of participation. However, we hear a different story from acute care referral sources.

In order for your IRF to accept an admission, do patients always have to be the ideal IRF candidate? Are they required to have an ironclad discharge plan or the absence of any social issues? Under your admission criteria that you communicate to referral sources, are you screening too many patients out of the IRF?

- *Admission process.* In many markets, IRFs must work hard to capture appropriate referrals.

Can your IRF admit a patient as rapidly as the competition, which may include skilled care or long-term care hospitals? Are your intake coordinators salespeople? Do you have enough people in the field developing and nurturing referral sources?

While these assessment areas are critical, they're just the beginning. To ensure a successful transition, convince referral sources that you can consistently accept and rehabilitate various high-need patient populations.

IRF providers have faced great challenges recently, and many providers are struggling with low census and decreased profitability. But a critical assessment of your program's current capabilities and a willingness to embrace significant program changes can increase admissions and lead to strong profit potentials. ■

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